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Reply to the Editor:

We thank Drs Nosotti, Simone, and Cioffi for their kind remarks and excellent commentary regarding our recent publication.[1] Endobronchial ultrasound-guided transbronchial needle aspiration (EBUS-TBNA) is truly an emerging technology that allows safe and accurate assessment of the mediastinum in patients with non–small cell lung cancer. We also anticipate the results of the ASTER trial[2] with hopes that it will further validate our findings.

We also understand the valid point made regarding the utility of rapid on-site evaluation during EBUS-TBNA. To this end, recent studies have sought to investigate the utility of rapid on-site evaluation.[3,4] However, in a practical sense, it may not always be possible to have access to the service of an experienced cytopathologist at all times during the performance of EBUS-TBNA. Practice patterns ultimately are developed with the resources that are available within a given institution.

Altogether, EBUS-TBNA provides a safe and reliable method of assessing the mediastinum in patients with non–small cell lung cancer. Whether the results are available instantaneously or in a couple of days, what matters the most is achieving an accurate result.

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BENEFITS AND RISKS OF USING CLOPIDOGREL BEFORE CORONARY ARTERY BYPASS SURGERY: A ROLE OF PLATELET FUNCTION ASSESSMENT

To the Editor:

We read with great interest the recently published systematic review and meta-analysis of randomized trials and observational studies by Biancari and colleagues.[1] When assessing the influence of preoperative antiplatelet therapy (APT) administration management on bleeding and adverse ischemic events, the objective quantification of platelet activity should inextricably be included in the considerations. Expected inhibition of platelet function is not always achieved after APT administration. The frequency of low responsiveness to aspirin and clopidogrel has been reported to range from 1% to 45% for the 2 drugs.[2] The efficacy of platelet inhibition with aspirin and clopidogrel varies widely among patients, from intensive platelet inhibition to poor platelet response. The effect of clopidogrel on bleeding mainly depends on 2 factors: (1) observed platelet inhibition, which depends on inherent platelet activity before clopidogrel administration and platelet inhibitory response to clopidogrel, and (2) the ability of newborn platelets to restore normal aggregation after clopidogrel discontinuation. This results in individual widespread variability in the activity of adenosine diphosphate platelet receptors, which consequently reflects similar variability in proclivity to excessive bleeding or adverse ischemic events. Awidi and colleagues[3] found that the combination of aspirin and clopidogrel had greater inhibitory effects on platelet aggregation than either agent alone. There is evidence that certain patients have an accentuated response to the usual doses of preoperative aspirin that may result in increased perioperative blood loss.[4] Therefore, the benefits and risks of using clopidogrel before coronary artery bypass grafting (CABG) should be individually assessed according to platelet function tests, and the role of aspirin should inevitably be included in the considerations. For patients receiving dual APT (aspirin + clopidogrel) before CABG, the influence of aspirin on bleeding and ischemic adverse events should be examined separately using an aspirin-sensitive platelet function test. The role of aspirin and clopidogrel should be assessed separately by drug-specific platelet function tests to provide the most precise and reliable information on the benefits and risks of preoperative administration for each antiplatelet agent, thus facilitating an individual approach to patients with the aim of reducing bleeding and adverse ischemic events. Evaluation of the effect of APT (aspirin or clopidogrel) on both bleeding and ischemic events should be based on platelet function assessment with subsequent distinction of patients with high residual platelet activity, thus a proclivity to ischemic events, or enhanced platelet inhibition, thus a proclivity to excessive bleeding. The group of patients with pronounced platelet inhibition observed during APT could benefit from early preoperative APT withdrawal in terms of excessive bleeding prevention. For patients undergoing CABG, individually tailored APT administration management based on platelet function tests, both pre- and